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Scott Harrington on Health Care Reform

Knowledge@Wharton: As the Supreme Court debates health care reform, we would like to ask you a couple questions about different aspects of the law, the possible outcomes and, given those, where health care reform goes from there. First of all, what seems to have sparked the debate over the individual mandate, which requires all adults to buy health insurance either through their employers or by purchasing it themselves? What are your views on this provision?

Scott Harrington: Individual views reflect one's attitude towards whether it is Constitutional, and then [his or her] attitude towards the economics. I primarily have considered the economics of the mandate. In principle, a mandate can help overcome a "free rider" problem where people might not buy health insurance and then get care in emergency rooms or in other contexts for which they can't pay, and to some extent the costs of that care may be shifted to other parties. So any economist [would say that] in principle, if you force people to buy health insurance, you can reduce that problem.

In practice, though, if you're going to have a mandate, you have to mandate that people buy something, and you have to specify the characteristics of what they have to buy. So it necessarily involves a considerable degree of government control over the underlying features of the insurance contract -- which, in this case, extends the federal government into defining the underlying features of an acceptable insurance contract in all states, in contrast to our historical practice where the states have basically had most responsibility for making any kinds of determinations about health insurance.

[Among] other things that I find questionable about a mandate, one would be that enforcement is likely to be imperfect. The mandate included in the Affordable Care Act has several features that would make enforcement less than perfect, including provisions in the law that say [the government is] not going to really go after people who don't pay the penalties. [Also,] the penalties themselves are quite small. They start off really small. To be sure, after three or four years, it will be $695 for an individual, up to 2.5% of a person's income, and family penalties will be greater than that. But [initially] the penalties themselves might be relatively modest, so as a practical matter, some people will avoid the mandate.

The other thing that is really important about the mandate enforcement and penalties, however, is that I don't think anybody believes we can have a law that says people have to buy medical insurance without providing extensive subsidies or exemptions to people, or low penalties so that people of modest means -- who predominantly are the people who do not buy health insurance -- don't really get hammered by the imposition of the mandate.

So, if you circle back to this free rider problem -- the fact that people don't buy insurance, and they may get care that other people pay for -- my impression is that cost is relatively modest. And when you fold in what the law has done in terms of stipulating the mandate, the cost of subsidies -- which would be paid by somebody, tax payers in general -- is going to be much greater than any benefit from reducing uncompensated care.

The other thing that the mandate involves as part of the overall law is that we're going to very much limit insurance companies' ability to, for example, set rates based on age, which will, in effect, require younger people to pay much more for insurance than they would without the mandate. To some extent, we're going to fund this subsidy delivery system. We're going to fund this procedure that is designed to get more people to have coverage by having young people face higher premiums than what we would if we stayed with the status quo. To be sure, many young people will be eligible for subsidies, so now they are going to face a product where they may get a premium subsidy, but they are facing a premium that, apart from any subsidies, is higher, perhaps significantly higher, than what they would pay without this law. And overall, the way that tax subsidy package works is much more complicated and problematic compared to the simple view that if we mandate something, we can overcome this free rider problem.

Knowledge@Wharton: Aside from the individual mandate, what is your opinion of the Affordable Care Act overall?

Harrington: I have published numerous op-eds in which I explained why I thought specific parts of the law were not in the public interest and that we could take an alternative, incremental approach to improving health care before moving in a fairly comprehensive direction as we did with the Affordable Care Act. The package that I believe would be appropriate, if we were to change the Affordable Care Act, would rely more on altering the system to improve incentives for consumers to consider the cost of their care, to shop for coverage, to be able to choose among insurance policies, and similar market-driven, market-oriented changes. Specifically, I think most people agree that we needed to do something to improve the portability of insurance coverage for people who have insurance -- say at work -- and then lose their jobs or want to change jobs. There is only an imperfect mechanism for such people to be able to get coverage without being underwritten by an insurance company and thus face possibly high premiums for having adverse health conditions or preexisting conditions.

We could have done many things to improve portability. One would have been a simple approach basically saying if a person has been continuously covered by health insurance and they lose coverage at one work site or they somehow lose their coverage, they are able to get coverage without regard to health status and preexisting conditions. Another thing we could have done is targeted people who for some reason don't get insurance when they are young and then later on decide that

they may need insurance but have adverse conditions or preexisting conditions. We could have expanded federal support for state-run, high-risk pools that would allow [these] people to get limited coverage, even though they have preexisting conditions, at rates that protect them from a lot of the increases that they would face in a perfectly private market.
A third thing -- and I think a lot of economists would agree with this -- is that we should have focused more attention on the tax code, which historically for people in middle to upper brackets has really encouraged them to accept compensation in the form of health insurance rather than the form of cash pay. Over time, the exclusion of the cost of health insurance from taxable income for people with middle and high incomes has encouraged them to load up on health insurance which provides broad choice and has limited co-payments, deductibles and the like. What you're doing with that system is encouraging perhaps the most educated part of the population, specifically the most affluent part of the population, not to choose their health insurance with an even trade off between health insurance and salary but to get more health insurance, which discourages them from paying close attention to the cost and increased overall cost.

The Affordable Care Act does do something. Beginning in 2018, high cost plans are going to have to pay a 40% excise tax. I regard that as a step in the right direction. I'm not sure I would have endorsed the specifics, but as an alternative to the Affordable Care Act, there are many proposals that would limit the tax subsidy to health insurance in ways that would encourage people who are working with coverage to consider more carefully whether they want policies with higher deductibles and higher co-payments in exchange for a lower premium, and I believe it would also encourage many workers to voluntarily choose managed care arrangements, such as health maintenance organizations, that would have other mechanisms built in to control costs. If you offer someone a significant premium reduction for going into a health maintenance organization where they may need to see a primary care physician before getting access to specialists, with limits on the tax subsidy, I believe you'll see more voluntary choice of those types of arrangements.

I would just add that [in] limiting the tax subsidy, there are technical details that can make it tough. But I think it would be very important to try to do that in a tax mutual way. I certainly would not favor eliminating the tax subsidy for health insurance or limiting it if you didn't somehow provide some offsetting reductions in taxes. The short version there is that I wouldn't endorse a tax increase without some offsetting reductions of other taxes if we move towards neutralizing the tax treatment of health insurance.

Knowledge@Wharton: Can you talk a little bit about the possible outcomes with the Supreme Court case, and where those might lead us?

Harrington: The case, of course, is complicated. There are three main issues. One is whether the law is ripe for adjudication prior to 2014. Another one is whether the

expansion of Medicaid inappropriately compels the states to participate. But really, the central issue is the individual mandate and whether it violates the Constitution. I'd be surprised if the decisions that come down really related to the issue of whether the law is ripe for adjudication. I'm less certain about what the court will say about Medicaid expansion. Regarding the individual mandate, there are basically four possible outcomes. One is that the court says it is constitutional, the entire law stands. The second is that the court says the individual mandate is unconstitutional, but they let the remainder of the law stand as it is, including the insurance reforms, community rating, guaranteed issue of coverage, no underwriting for preexisting conditions, the creation of health insurance exchanges and the like. A third possible outcome is that the court says we invalidate the individual mandate -- and because the insurance reforms are integrated with the individual mandate and the entire package really consists of an integrated whole, they get rid of title one, which basically is all the insurance reforms including the insurance exchanges. The fourth possibility -- perhaps if they also frown upon the Medicaid expansion -- is for them to declare the individual mandate unconstitutional and void the entire act, to basically say that the entire law is inseparable from the individual mandate.

I would be more surprised than not if the court allows the individual mandate to stand and just basically says the law is okay. I think there's a good chance of that, but based on reading the transcripts of the court and doing a little bit of court watching like other people do, I'm inclined to think that the court will declare the individual mandate unconstitutional. If they do that, I would be surprised if they declare the entire law unconstitutional. I wouldn't be astounded, but I would basically be surprised. I think given that they would [likely] invalidate the individual mandate, probably what we're going to get is [them saying]: "We'll isolate the mandate, and everything else stands." Or they will get rid of large portions or all of title one, which is the package of insurance reforms of which the individual mandate would be deemed to be an integral part. So that's sort of in the ranking, I think. The two most likely outcomes are they repeal the mandate and either leave everything else, or they repeal the mandate and the related insurance reforms.

Knowledge@Wharton: So if they repeal the mandate, or repeal the mandate and end the related insurance reforms, what would you say is most likely to happen next? Would Congress and the Obama administration go back to the drawing board? Is there a way to maybe improve what's there? Where does health care go from here?

Harrington: If the court were to invalidate the individual mandate but leave everything else standing, it's difficult to predict what the Congress might do for obvious reasons, especially given the election and that we might have a change of presidents. If the entire law were to remain but for the mandate, I believe it would be likely that the Congress would take legislative action to reduce some of the adverse effects of having eliminated the mandate. If the mandate is eliminated and everything else is allowed to stand, it will exacerbate the problem that's going to

arise with the current law, which is that there will be a disproportionate number of people in poor health who will comply with the mandate and seek coverage under the guaranteed issue and community rating of individual coverage. We call that the "adverse selection" issue. Some people call it a death spiral issue. Because the penalties for non-compliance with the mandate are already low, I'm one of the people who think there will be a non-trivial amount of adverse selection which will put upward pressure on premiums in the exchanges and the individual coverage -- that there will be strong cost growth because of adverse selection in those markets. The way the subsidies are designed, the federal government will end up picking up a large part of the cost if we do see that disproportionate risk selection and more sick people going into the pools. That will create more strains obviously on the federal budget and the deficit.

We already are going to have that problem to some extent. Some people have said the mandate is so weak that getting rid of it probably won't matter that much. I have to think it will matter. I can't quantify how much, but I think there's a difference between a penalty that could be 2.5% of one's income and no penalty at all. Plus, [there is] the ethical component: Some people comply with the government law, an important government law; they don't look just at the penalty and do an economic calculation. So, I think if we get rid of the mandate, the adverse selection problem will be worse. It probably will create enough concern that if we don't revisit the entire health care space, Congress will do something to limit adverse selection which would involve allowing a window of opportunity for people to get coverage without being underwritten. And if they don't get coverage within a certain window, maybe they face potentially higher premiums if they have health conditions.

There are steps that can be taken to limit the adverse selection, but in the big picture, if the mandate itself goes but everything else stands, it is more likely that we're going to end up with the overall structure of the law going forward. But, depending on what happens with the November elections, if the mandate goes and the health insurance reforms go, community rating, preexisting conditions, limitations on preexisting conditions, even eliminating the part of the law that would create state-based health insurance exchanges, that makes it more likely politically that some sort of overall alternative to the ACA gets legs in the Congress. Clearly, if the Republicans were to get a majority in the Senate and if we had a Republican president, the campaigns are saying that we will do a repeal-and-replace kind of scenario regardless of what the court does. I think the court's decisions could influence the ultimate outcome.

Knowledge@Wharton: Are there any initiatives currently in progress or things going on elsewhere that you could see as a model in terms of working well?

Harrington: There have been proposals around for many years that I would describe as market-oriented, consumer-centric proposals for reforming health care, and I talked a little bit about this a few minutes ago. But no one in the political

domain has really put out a hard and fast plan. It's all sort of generic. These are the broad points, but I think the broad points are good ones. Just to reiterate -- one thing is ... that we can do things to greatly improve [insurance] portability. We've already got laws that enhance portability significantly, but there are gaps, and we can close those gaps.

The second thing I mentioned is thinking very carefully about the tax subsidies that exist, which are especially pronounced for middle and upper income tax payers [and encourage them] to load up on generous insurance with free choice of providers, putting strong upward pressure on cost. We can help reduce cost by rationalizing the tax treatment of health insurance and wages to make people more neutral about whether they want more generous health insurance with choice of provider, or whether they are willing to accept some restrictions on choice of provider and greater co-payments for their health insurance in exchange for getting take home pay.

Third, I think we need to look very carefully at targeted areas where we can provide, as a nation, greater subsidies to people of modest means to get health insurance. Clearly, that's a major part of the Affordable Care Act. There are less intrusive, less costly and more targeted methods of basically saying, "How big do we want this safety net to be? How can we provide subsidies that will provide as few distortions as possible for incentives to people at work?" But I believe even most conservative members of Congress and people who are running for office would be open minded to an expansion of the safety net. To be sure, given federal deficit concerns, it's a hard sell and it's hard to think about how we are going to get the dollars. But if the Affordable Care Act were replaced, there's some room to maneuver to simultaneously think, "Can we provide more help to people with low income in order for them to get health care?"

And the fourth thing, again, is for people who fall between the cracks and end up without insurance -- they don't have the portability, they don't have continuous coverage, they need insurance and now they've got a preexisting condition that's very expensive to insure. Have a safety valve in place. Expand state-level, high-risk pools, with more federal money for those pools -- but it's important to have some sort of penalty if a person waits to get coverage until they really need it. So you can't really say, "We're going to give you coverage at the same terms and conditions you would get if you were healthy." I don't think that works, but we can provide some overall level of expanded safety nets.

Now, we have a big picture going forward. How do we help control costs and improve quality of care, or at least not reduce quality of care? One philosophical view is to say if we can engage consumers more [regarding] their decisions about their health care and their health insurance, that will, over time, create incentives that will help control costs. I think it's worth it to move in that direction -- to see, incrementally, if we try a consumer-oriented model and we get benefits. If it doesn't work and we continue to have crises after crises with health care, then you

can think about more top down, centralized approaches to limiting the amount of care that's provided in order to make it affordable.

I would add that regardless of how the ACA plays out, we're going to have a battle over Medicare funding.... Even if the court allows the ACA to stand, and even if the election doesn't change the dynamics so that there could be a repeal of the law or a substantial modification of the law, sometime during the next two, three, four or five years, we are going to have a major debate in the United States about what we should do about Medicare to make it fiscally sustainable over the long run. We're also going to have a major debate about Medicaid and how to make it fiscally sustainable at the federal and the state level over the long run. Those battles are going to be fought with tremendous implications for the future of the country, regardless of how the Affordable Care Act plays out before the courts or in the Congress.